BODYWORK & WELLNESS

MASSAGE INTAKE FORM/HEALTH HISTORY

Name_____ Date___/___/_____

Address_____
(Street) (City / State / Zip)

Phone#_____ Date of Birth___/___/_____

Emergency Contact_____ _____
(Name & Phone#) (Relationship)

Occupation_____ Email_____
*We will only use your email address for official Sage Bodywork communications.

How did you hear about us?_____

HEALTH HISTORY

(Please answer all questions completely)

Have you had massage before? YES / NO If yes, what type of pressure do you prefer? LIGHT MEDIUM DEEP

What is the goal for today's visit?_____

Describe any symptoms you are having _____

Conditions or symptoms you have currently or previously experienced:		Allergies/Sensitivities (Scents/Seasonal/Tree Nut)
☐ Headaches	☐ Arthritis (of any type)	_____
☐ Dizziness	☐ Circulatory Disorder	_____
☐ Numbness	☐ Diabetes	_____
☐ Chest Pain	☐ High or Low Blood Pressure	_____
☐ Cancer (of any type)		

Please list any medications you are currently taking:

_____

Are you currently under the care of a doctor for any specific condition? Yes / No If yes, please list:

_____

_____

Please list any surgeries/falls/accidents and date of occurrence:

_____

_____

Are you or could you possibly be pregnant? Yes / No

Are you aware of any reason why you should not be receiving massage? Yes / No

Continued on back

INFORMED CONSENT STATEMENT

By signing, I hereby consent to the application of massage therapy performed by the therapist named below. Massage therapy consists of soft tissue manipulation using techniques such as, but not limited to, compression, gliding, fascial release, stretching and mobilization. The therapist may also employ the use of heat and/or cold applications if deemed appropriate for my condition or symptoms. All massage therapy services are performed by professional and insured massage therapists licensed in the State of Illinois.

I understand that an important effect of massage therapy is increased blood circulation, and that treatment may be refused if my condition or symptoms contraindicate this effect. Furthermore, I have disclosed any health information that may affect the therapist's decision to perform massage therapy. Benefits of massage therapy may include stress reduction, increased range of joint motion, pain relief, and improved posture. I understand that there are some slight risks associated with massage therapy, such as muscle soreness or tenderness and bruising. I also understand that my therapist cannot anticipate all risks associated with massage therapy, and that this treatment is in no way a substitute for regular medical advice or care. I agree to inform my therapist if muscle soreness, tenderness and bruising persist for 48 hours or more.

I also understand that the massage therapist depends on my communication and feedback, and agree to inform my therapist of any need to adjust pressure, whether more or less, during the course of the session. I have had an opportunity to discuss my questions and concerns with my therapist at any time during my scheduled appointment.

Client Name (printed) Client Signature Date

Therapist Name (printed) Therapist Signature Date

(Therapist use only)

S: _____

O: _____

A: _____

P: _____